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January 16, 2009

MEMORANDUM

TO: Legislative Oversight Committee
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Professional and Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
MH/DD/SAS Stakeholder Organizations

FROM: Tara Larson
Leza Wainwright

Please read carefully – this information supersedes the January 14, 2009 DMA/DMH Implementation memo #52.

EDS system modifications are in the process of being completed which will allow Community Support providers to bill the tiered rates outlined below. This information is being distributed now to allow providers to prepare their systems for the up coming billing changes. As providers read this information, they should be aware the following key dates.

- Claims submitted after 5:00 pm on January 22, 2009 will need to be billed using the new community support tiered rates process. These claims will be adjudicated in the cycle which will run the weekend of January 30, 2009 for the check write scheduled for February 3, 2009.

- Any claims submitted with the new community support tiered rates and secondary modifiers **before** the January 22, 2009 electronic cut-off will be denied.

Attention: Enhanced Mental Health and Substance Abuse Service Providers

Community Support Services – Tiered Rates

The General Assembly enacted Session Law 2008-107 Section 10.15A(a)(b), which changes the payment methodology of Community Support services from a blended rate to a tiered rate based upon the individual

qualifications of the staff providing the service. The Division of Medical Assistance (DMA) submitted a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid (CMS) for approval to implement these changes. **The SPA has been approved effective with date of service January 1, 2009.**

For dates of service December 1, 2007 through December 31, 2008, providers are instructed to apply secondary modifiers U3 or U4 to identify units of service provided by the Qualified Professional (QP) and Non-Qualified Professional (non-QP) staff persons. Effective with date of service January 1, 2009, these two secondary modifiers will no longer be appropriate after date of service December 31, 2008 and have been replaced by eight new secondary modifiers effective with date of service January 1, 2009 (refer to the tables below).

Community Intervention Services (CIS) providers billing for Community Support services are required to apply these new secondary modifiers on claim submissions for procedure code H0036 in addition to the required primary modifier:

- H0036 HA – Community Support Child
- H0036 HB – Community Support Adult
- H0036 HQ – Community Support Group

The rates associated with the four levels of staff credentials have been approved by the Medicaid Rate Review Committee and CMS. Please note that these final rates represent a change from the proposed rates which were posted on the DMA web site.

H0036 HA - Community Support Child

Staff Level	Code	First Modifier	Second Modifier	Unit Rate
Qualified Professional - Licensed	H0036	HA	HP	$22.04
Qualified Professional – Unlicensed	H0036	HA	HO	$18.25
Associate Professional	H0036	HA	HN	$10.29
Paraprofessional	H0036	HA	UB	$5.92

H0036 HB - Community Support Adult

Staff Level	Code	First Modifier	Second Modifier	Unit Rate
Qualified Professional - Licensed	H0036	HB	HP	$22.04
Qualified Professional – Unlicensed	H0036	HB	HO	$18.25
Associate Professional	H0036	HB	HN	$10.29
Paraprofessional	H0036	HB	UB	$5.92

For H0036 HQ – Community Support Group, a separate set of modifiers will be necessary.

Staff Level	Code	First Modifier	Second Modifier	Unit Rate
Qualified Professional - Licensed	H0036	HQ	U8	$ 7.09
Qualified Professional – Unlicensed	H0036	HQ	U7	$ 5.87
Associate Professional	H0036	HQ	U6	$ 3.31
Paraprofessional	H0036	HQ	U5	$ 1.90

Authorizations for all Community Support services will continue at the aggregate level with payment at the detail level. Providers should not resubmit previously submitted prior authorization requests for CS services. The process of submitting a prior authorization request for CS services will not change. **Previously paid claims with a U3 or U4 secondary modifier for dates of service on or after January 1, 2009, will require a replacement claim to be filed with EDS. Please refer to the June 2007 Medicaid Bulletin for details on submitting replacement claims. Providers have until April 30, 2009 to submit replacement claims. After that time, automatic recoupments will be performed on claims paid with the U3 or U4 modifier for dates of service on or after January 1, 2009.** It is recommended that providers separate all claim details for Community Support services for dates of service before or after January 1, 2009, to assure efficiency in payment.

Each claim for Community Support services will require the use of the two modifiers to be processed for payment. Primary modifiers HA, HB, or HQ must be placed in the first modifier position on the corresponding claim detail line. Secondary modifiers must be placed in the second modifier position on the corresponding claim detail line. **Payment of the claim is driven by the second modifier. Errors in entering the correct second modifier could result in recoupment upon audit of medical records.**

CMS-1500 Claim Examples:

These examples are for illustration purposes only. Actual codes billed should reflect who rendered the services.

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $CHARGES	G. DAYS OR UNITS
01	12	09	01	12	09	11		H0036	HA HO	1	73.00	4
01	12	09	01	12	09	11		H0036	HA UB	1	47.36	8
01	12	09	01	12	09	11		H0036	HA HN	1	41.16	4
01	12	09	01	12	09	11		H0036	HQ U7	1	23.48	4

Below are guidelines to assist providers in accuracy of claim submission:

- Providers should bill only one line each for primary and secondary modifier combination per date of service per client. If more than one staff person with same level of credentials provides services on the same date, these staff units should be rolled into one detail line.
- It is expected that any combination of staff and associated modifiers may be billed on the same date of service.
- The determination of staff qualifications is dictated by the staff credentials providing the service; not the actual intervention.
- No rounding of time is allowed for billable services; only round down when time does not reach a complete 15 minutes per individual staff rendering the service.
- The maximum of 32 units per week for per adult client (H0036 HB) is applied to the combined total of all modifiers and units of service.

NOTE REGARDING BILLING IPRS FOR COMMUNITY SUPPORT SERVICES

IPRS billing for Community Support will follow the same protocol as Medicaid for the billing of Community Support, and the effective date is January 1, 2009.

If you should have any questions regarding this information, please contact Behavioral Health Services at DMA at 919-855-4290 and for questions about IPRS, please contact 919-733-4460.

cc: Secretary Lanier Cansler
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